Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MAINLAND SURGERY CENTER
3750 MEDICAL PARK DRIVE SUITE 300
DICKINSON TX 77539

Respondent Name
ARGONAUT INSURANCE CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-11-3126-01

MFDR Date Received
MAY 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid per DWC Guideline"

Amount in Dispute: $4,755.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4, 2010	ASC Services for CPT Code 63650-SG & 63650-SG-59	$4,755.85	$4,755.85

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 28, 2010
   - 329-allowance for this service represents 50% because of multiple or bilateral rules.
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - Processed based on multiple or concurrent procedure rules.
   - 793-Reduction due to PPO contract.

Explanation of benefits dated January 3, 2011

- 45-Charges exceed your contracted/legislated fee arrangement.

Explanation of benefits dated April 20, 2011

- F22-Allowance for this procedure was reduced to 50% of the prevailing charge, as multiple procedures were performed during the same session.

Explanation of benefits dated May 2, 2011

- 224-A charge was made for a duplicate procedure and/or supply.

Issues

1. Does a contractual agreement issue exist?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. The "PPO Discount" amount on the submitted explanation of benefits denotes a $0.00 discount was taken. The Division finds that the respondent did not submit a copy of a contractual agreement to support that a contract exist. Therefore, the disputed services will be reviewed per applicable Division rules and guidelines.
2. CPT code 63650 is described as "Percutaneous implantation of neurostimulator electrode array, epidural"

   Per ADDENDUM AA, CPT code 63650 is a device intensive procedure and is exempt from the multiple procedure rule discounting.

   Division rule at 28 TAC §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

   Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) reimbursement for device intensive procedure code 63650 is a two step process:

   Step 1 calculating the device portion of the procedure:

   The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 63650 for CY 2010 = $4,429.21.

   This number multiplied by the device dependent APC offset percentage found in the Addendum B for National Hospital OPPS reimbursement of 58% = $2,568.94.

   Step 2 calculating the service portion of the procedure:

   The Medicare fully implemented ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures fully implemented ASC relative payment weight for CY 2010 = 86.962.
   This number is multiplied by the 2010 Medicare ASC conversion factor of 86.962 X $41.873 = $3,641.35.
   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $1,820.67 ($3,641.35/2).

   This number X City Conversion Factor/CMS Wage Index for Dickinson, Texas is $1,820.67 X 0.9841 = $1,791.72.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $1,820.67 + $1,791.72 = $3,612.39.

   The service portion is found by taking the national adjusted rate of $3,612.39 minus the device portion of $2,568.94 = $1,043.45.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,043.45 X 235% = $2,452.10.

The MAR is determined by adding the sum of the reimbursement for the device portion of $2,568.94 + the geographically adjusted service portion of $2,452.10 = $5,021.04.

The requestor billed for 2 units of CPT code 63650; therefore, $5,021.04 X 2 = $10,042.08. The insurance carrier paid $2,829.92. The difference between amount due and paid equals $7,212.16. The requestor is seeking additional reimbursement of $4,755.85; this amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement to the requestor. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,755.85.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,755.85 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		7/26/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.